

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01955

1952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD. # 3				d. STREET ADDRESS R.F.D. # 3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ethel Middle M. Last Almony				4. DATE OF DEATH Month Feb. Day 2 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1896		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Madona, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Fehrman				14. MOTHER'S MAIDEN NAME Mamie Fehrman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Carroll E. Almony, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (d), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 4 yrs (c)							INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 58 to Feb 2 , 19 59 , that I last saw the deceased alive on Feb 2 , 19 59 , and that death occurred at 2:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt Airy Md DATE SIGNED CM 1/20/59							
ACTUAL SIGNATURE CM 1/20/59		PHYSICIAN'S NAME (Type) CM 1/20/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1959		22c. NAME OF CEMETERY OR CREMATORY Salem		22d. LOCATION (City, town, or county) (State) Madona, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE FEB 5 '59	
				24b. REGISTRAR'S SIGNATURE Carroll E. Almony			

CERTIFICATE OF DEATH

1922

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1922		Boston, Mass.		Heart Disease	
Time of Death		Physician		Manner of Death	
10:00 AM		Dr. J. Smith		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
City		County		State	
Boston		Suffolk		Mass.	
Occupation		Education		Religion	
Teacher		High School		Catholic	
Marital Status		Previous Illnesses		Previous Injuries	
Married		None		None	
Date of Birth		Place of Birth		Date of Admission to Hospital	
Jan 1, 1877		Boston, Mass.		Jan 1, 1922	
Date of Death		Time of Death		Place of Death	
Jan 1, 1922		10:00 AM		Boston, Mass.	
Cause of Death		Manner of Death		Signature of Coroner	
Heart Disease		Natural		[Signature]	
Physician		Signature of Registrar		Signature of Coroner	
Dr. J. Smith		[Signature]		[Signature]	
City		County		State	
Boston		Suffolk		Mass.	
Occupation		Education		Religion	
Teacher		High School		Catholic	
Marital Status		Previous Illnesses		Previous Injuries	
Married		None		None	
Date of Birth		Place of Birth		Date of Admission to Hospital	
Jan 1, 1877		Boston, Mass.		Jan 1, 1922	
Date of Death		Time of Death		Place of Death	
Jan 1, 1922		10:00 AM		Boston, Mass.	
Cause of Death		Manner of Death		Signature of Coroner	
Heart Disease		Natural		[Signature]	
Physician		Signature of Registrar		Signature of Coroner	
Dr. J. Smith		[Signature]		[Signature]	
City		County		State	
Boston		Suffolk		Mass.	
Occupation		Education		Religion	
Teacher		High School		Catholic	
Marital Status		Previous Illnesses		Previous Injuries	
Married		None		None	
Date of Birth		Place of Birth		Date of Admission to Hospital	
Jan 1, 1877		Boston, Mass.		Jan 1, 1922	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

REPLACEMENT
CERTIFICATE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1953

Replacement Certificate Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodlawn Farm		d. STREET ADDRESS Woodlawn Farm	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vivian Middle Loretta Last Anderson		4. DATE OF DEATH Month February Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1958
9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR Months 4 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Olney, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon E. Anderson		14. MOTHER'S MAIDEN NAME Rosalie Bell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Vernon Anderson, Ellicott City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to bilateral otitis media. 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-59	
22c. NAME OF CEMETERY OR CREMATORY Bushy Park		22d. LOCATION (City, town, or county) (State) Cooksville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR APR 17 '59	
		24b. REGISTRAR'S SIGNATURE Robert L. P. [Signature]	

2073172xv1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1908

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

NOSE

MOUTH

THROAT

STOMACH

INTESTINES

BLADDER

RECTUM

UTERUS

VAGINA

TESTES

PROSTATE

SEMINAL VESICLE

URETER

URETHRA

PISSARIUM

SCROTUM

PHALLUS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1954

CERTIFICATE OF DEATH

01957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer Nursing Home Columbia Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Gordon Last Barton				4. DATE OF DEATH Month February Day 26 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1880		9. AGE (In years last birthday) 78	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Adam Noon				14. MOTHER'S MAIDEN NAME Ada Seibert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Francis L. Dunphy, 37 North Prospect Ave Catonsville 28			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24 , 19 59 , to 2/26 , 19 59 , that I last saw the deceased alive on 2/24 , 19 59 , and that death occurred at 11:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 460 Church Rd. Ellicott City, Md. DATE SIGNED 3/28/59							
ACTUAL SIGNATURE Thomas F. Herbert M.D.		PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-2-59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE MAR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
b
M
00
I
0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1955

CERTIFICATE OF DEATH

01958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 27, Dorsey				c. LENGTH OF STAY IN 1b 38 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dorsey Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle E. Last CASSADY				4. DATE OF DEATH Month February Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Oct. 1890.		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen'l. Store Op. (ret.) Self Emp.				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME James B. Cassady				14. MOTHER'S MAIDEN NAME Clara R. Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 219-32-1860		17. INFORMANT Mrs. Rovena Cassady Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia 162.1 DUE TO Metastasis to brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. of medication DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 mo 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) (County) (State) 				21. I certify that I attended the deceased from Feb. 20, 1959 to Feb. 21, 1959 , that I last saw the deceased alive on Feb. 20, 1959 , and that death occurred at 4:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B B Brumbaugh M.D.				ADDRESS (Street, city or town, state) 5609 main st DATE SIGNED 2/23/59			
PHYSICIAN'S NAME (Type) B B Brumbaugh				ADDRESS Elbridge 27 mo			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24/59		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) Howard Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard V. Smyth ADDRESS Glen Burnie, Md.				24a. RECEIVED BY REGISTRAR FEB 26 59 DATE 		24b. REGISTRAR'S SIGNATURE Cashup L. Hanks	

14



10

1997

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1956

01959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b X Elkridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6319 Old Washington Blvd.				d. STREET ADDRESS 6319 Old Washington Blvd.	
3. NAME OF DECEASED (Type or print) WALTER P. CIEPIELA		4. DATE OF DEATH Feb. 25, 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Poland		11. BIRTHPLACE (State or foreign country) U S A	
13. FATHER'S NAME John Ciepiela		14. MOTHER'S MAIDEN NAME Agatha Wujcik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW 1 Polish Army		16. SOCIAL SECURITY NO. 216-32-9260		17. INFORMANT Walter Ciepiela, Elkridge, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE George E. Burgtorf		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Feb. 25, 1959	
EXAMINER'S NAME (Type) George E. Burgtorf MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/59	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) 1300 Dundalk Ave Balto, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber 705 S Ann st		24a. REC'D BY REGISTRAR FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1958

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW/STP

CONFIDENTIAL

1. Name of decedent: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Signature of medical examiner: [illegible]
7. Signature of coroner: [illegible]
8. Signature of physician: [illegible]
9. Signature of funeral director: [illegible]
10. Signature of other: [illegible]

1957

CERTIFICATE OF DEATH

01960

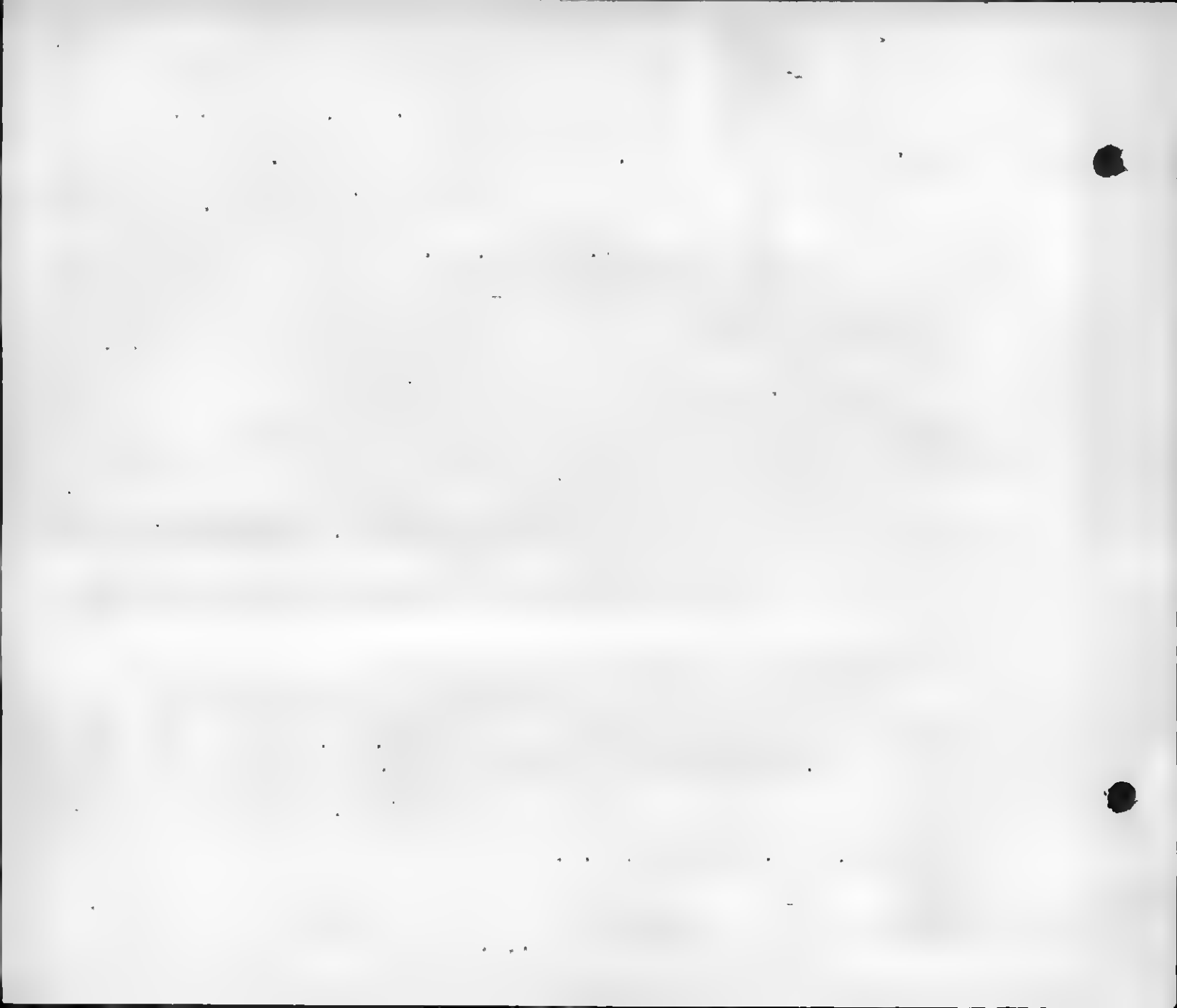
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. 19. b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville				c. LENGTH OF STAY IN 1b 1yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hinkson Baby Home				d. STREET ADDRESS 5337 Addison Chapel Rd.			
3. NAME OF DECEASED (Type or print) First Ernest Middle L. Dunbar, Jr. Last 				4. DATE OF DEATH Month 2 Day 10 Year 1959			
5. SEX M	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-58		9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest L. Dunbar				14. MOTHER'S MAIDEN NAME Edna Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Edna Dunbar Address 5337 Addison Chapel Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 752x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Internal hydrocephalus, congenital DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 3 months 13 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 31, 1958 , to Feb. 10, 1959 , that I last saw the deceased alive on Feb. 7, 1959 , and that death occurred at 3:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Maryland DATE SIGNED 2-10-59							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.		PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle Collins		ADDRESS 4339 Hunt Pl., N.E.		24a. REC'D BY REGISTRAR FEB 13 59		24b. REGISTRAR'S SIGNATURE William S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in Pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01961

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge Rural</u>		c. LENGTH OF STAY IN 1b <u>7 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge, Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Rd. Elkridge</u>				d. STREET ADDRESS <u>Montgomery Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>HAFNER</u> Last <u>HAFNER</u>				4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-20-1892</u>		9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics Helper BRQ</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN G. HAFNER</u>				14. MOTHER'S MAIDEN NAME <u>MADELINE SCHLEICHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-07-8756</u>		17. INFORMANT <u>Andrew Purkett</u> Address <u>Montgomery Rd. Elkridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>4 years</u>							INTERVAL BETWEEN ONSET AND DEATH. <u>10 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George E. Burgtorf</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>George E. Burgtorf M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>16 Feb 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry M. Walters</u>				ADDRESS <u>1311 Pratt St. Baltimore, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 1959</u>	
				24b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

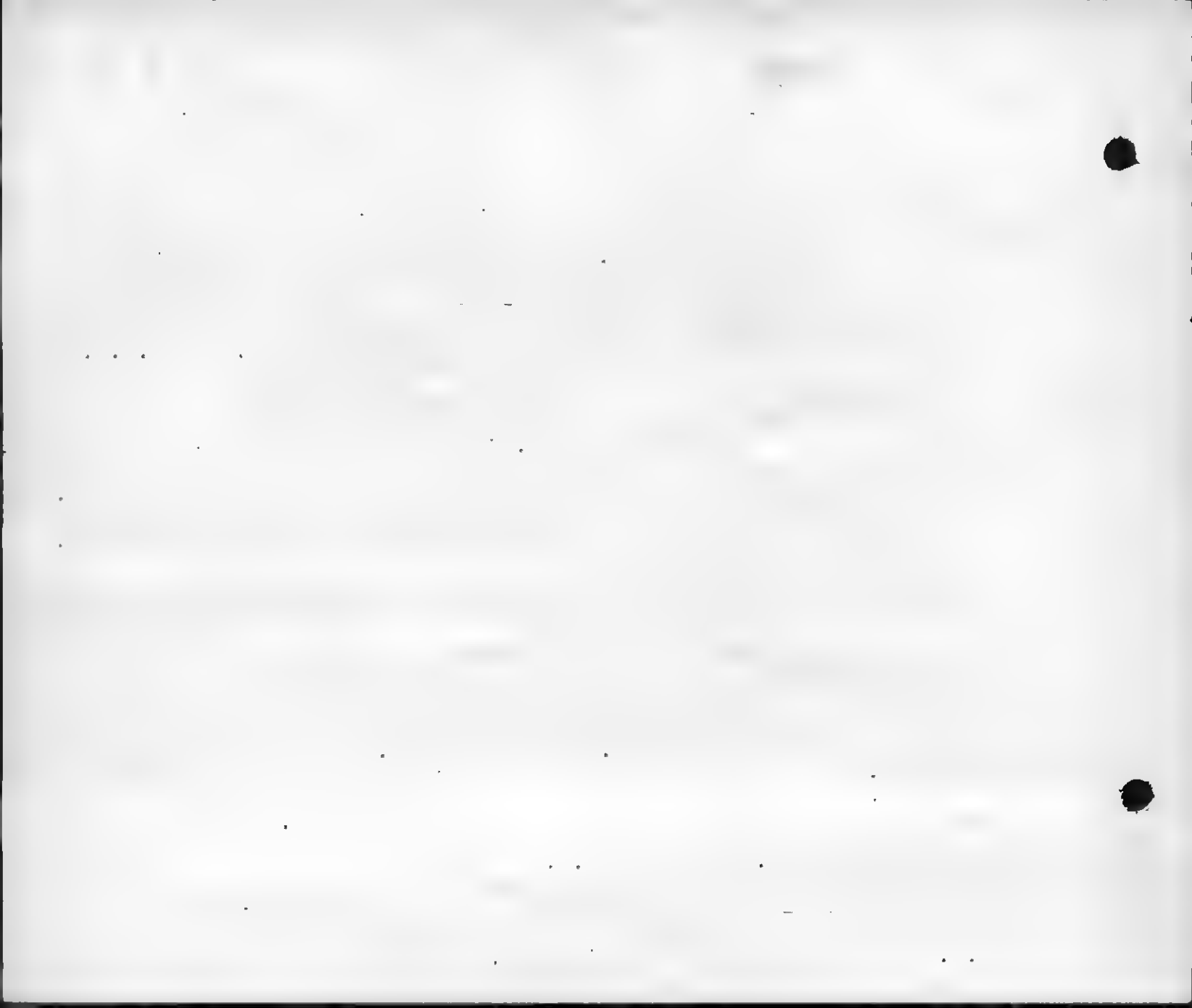
Reg. Dist. No.

01962

1959

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b 85 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Centennial Lane		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City STREET ADDRESS Centennial Lane e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Victor Middle B. Last Iglehart		4. DATE OF DEATH Month February Day 25 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-73
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Ellicott City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus Iglehart		14. MOTHER'S MAIDEN NAME Elizabeth Phelps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-36-5004	
17. INFORMANT Mrs. Florence Iglehart, Ellicott City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary artery occlusion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH instant.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25, 1959 to Feb. 25, 1959 , that I last saw the deceased alive on Feb. 25, 1959 , and that death occurred at 8:00 P M, from the causes and on the date stated above ADDRESS (Street, city or town, state) Clarksville, Md. DATE SIGNED February 26, 59			
ACTUAL SIGNATURE Charles S. Whitaker, M.D.		MEDICAL CERTIFICATION	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-28-59	
22c. NAME OF CEMETERY OR CREMATORY Mount View		22d. LOCATION (City, town, or county) (State) Alpha, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAR 2 '59		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

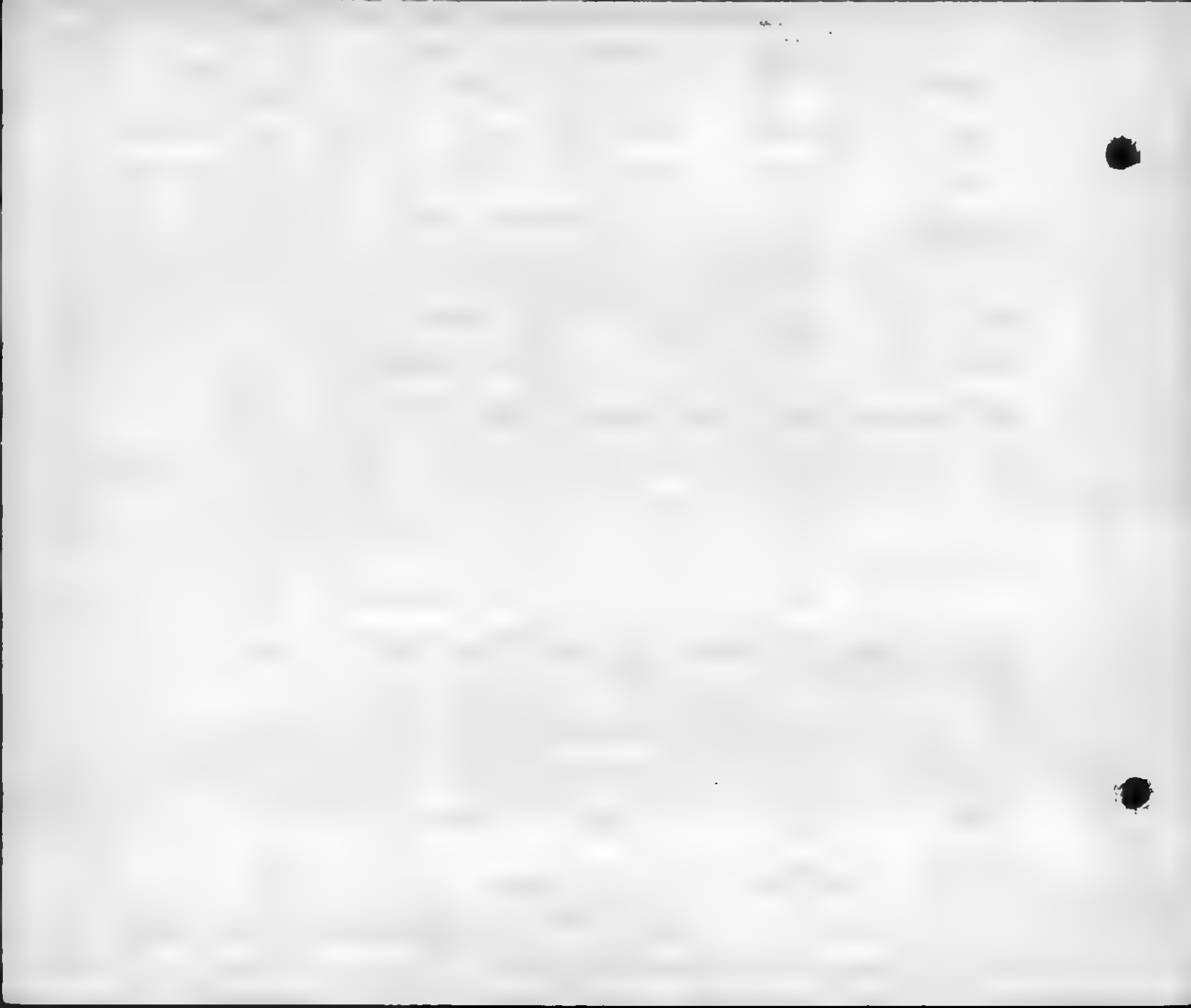
1960

CERTIFICATE OF DEATH

Reg. Dist. No.

01962

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>			
c. LENGTH OF STAY IN 1b <u>few days</u>				d. STREET ADDRESS <u>1524 McHenry St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1917 Railroad Ave</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS</u> <u>JOSEPH</u> <u>KISNER</u>				4. DATE OF DEATH Month Day Year <u>Feb</u> <u>19</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>freeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Free Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Aloysius Kisner</u>		14. MOTHER'S MAIDEN NAME <u>Unknown to inform</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Daughter - Evelyn O'Brien - 1917 Railroad Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>33ix</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>noon</u> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1 Jan</u> , 19 <u>58</u> , to <u>19 Feb</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12 Feb</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Goodman</u> M.D.				ADDRESS (Street, city or town, state) <u>1334 Sulphur Spring Rd - Balt - Md</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u>				DATE SIGNED <u>Balto, 27, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose Inc. 1328 Sulphur Spring Rd</u>				ADDRESS <u>1328 Sulphur Spring Rd</u>		24a. REC'D BY REGISTRAR <u>Feb 27 1959</u>	
						24b. REGISTRAR'S SIGNATURE <u>Wm J. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1961

CERTIFICATE OF DEATH

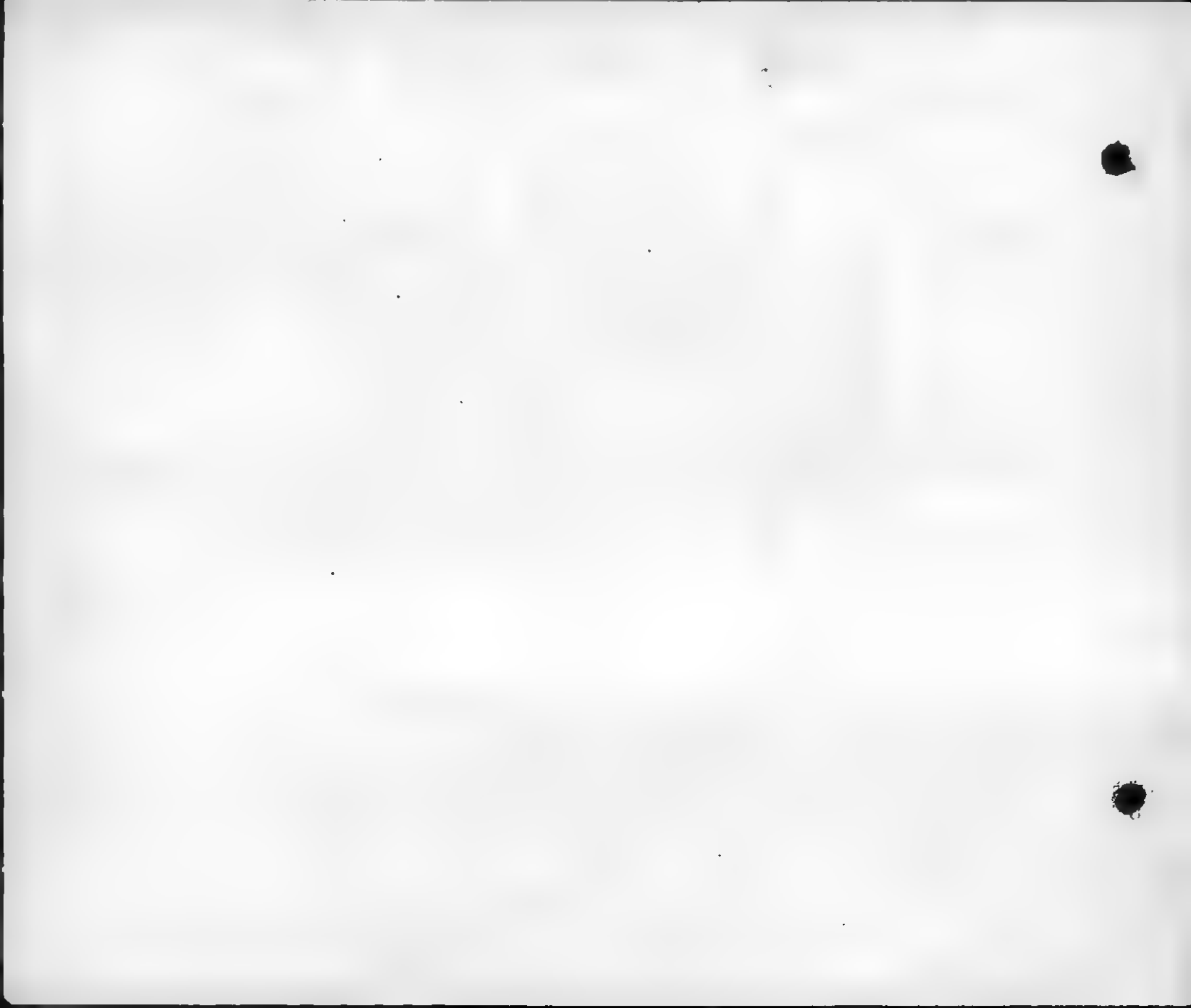
01964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLAYTON E. McDONALD</u>		4. DATE OF DEATH <u>Feb. 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1915</u>
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marriage man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road Comm.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward Mc Donald</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kraft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>219-20-1537</u>	
17. INFORMANT <u>Virginia R. McDonald - Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma lungi generalized</u>		<u>1958</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>arteriosclerosis, emphysema, hypertension</u>	
(c)		<u>27 Feb 59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>27 Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>27 Feb</u> , 19 <u>59</u> , and that death occurred at <u>5 A. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>27 Feb 59</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>34 KESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Hight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hight</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1962

CERTIFICATE OF DEATH

01965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GUILFORD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GUILFORD MD</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WALTER</u> First <u>MOORE</u> Middle <u>MOORE</u> Last		4. DATE OF DEATH <u>FEB. 20</u> 19 <u>59</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 20 1889</u> 72 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours M.n.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard County, Md</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE MOORE</u>		14. MOTHER'S MAIDEN NAME <u>CASSIE THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>HENRY MOORE, JESSUPS, R.F.O</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>15 yrs</u> <u>20 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Latent Syphilis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/2</u> 19 <u>41</u> to <u>2/21</u> 19 <u>59</u> that I last saw the deceased alive on <u>2/19/59</u> 19 <u>59</u> and that death occurred at <u>9A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J M Warren</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Feb. 24/59</u>	<u>ASBURY CEMETERY</u>	<u>NEAR SAVAGE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u> ADDRESS <u>1200 Snowden Place</u>		24a. REC'D BY REGISTRAR <u>FEB 24 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE	



1963

CERTIFICATE OF DEATH

Reg. Dist. No.

01966

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harman's Nursing Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MICHAEL NAHALKA				4. DATE OF DEATH Month Day Year Feb. 22, 1959 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1974	
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
13. FATHER'S NAME Michael Naholka				14. MOTHER'S MAIDEN NAME Mary ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 148-09-1962		17. INFORMANT Address Mr. Elmer D. Snook, Simpsonville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SENILITY 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RENAL, BOWEL, MYOARTERIAL - CRANIAL, RETINAL, etc.							INTERVAL BETWEEN ONSET AND DEATH 10-12
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1, 1974 , to Feb. 22, 1959 , that I last saw the deceased alive on Feb. 22, 1959 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Donald E. Fisher M.D. 2-26-59							
ACTUAL SIGNATURE Donald E. Fisher M.D.							
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D. Elmer D. Snook M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-59		22c. NAME OF CEMETERY OR CREMATORY Union Hollywood		22d. LOCATION (City, town, or county) (State) Union N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE FEB 25 59		24b. REGISTRAR'S SIGNATURE Wm J. Fisher	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1964 CERTIFICATE OF DEATH

01967

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MARYLAND Howard				2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksville				c. LENGTH OF STAY IN 1b X Clarksville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 32				e. STREET ADDRESS Rt. 32		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JESSIE HOBBS SCOTT				4. DATE OF DEATH Month Feb. Day 26 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-1880	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	
10b. KIND OF BUSINESS OR INDUSTRY Alpha, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Wesley Hobbs				14. MOTHER'S MAIDEN NAME Elizabeth Ridgley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT J. William Scott, Clarksville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza DUE TO (c) Stroke						INTERVAL BETWEEN ONSET AND DEATH 1 day 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 1959, to 2/26 1959, that I last saw the deceased alive on 2/24 1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. P. Warren M.D.				ADDRESS (Street, city or town, state) Laurel Md			
PHYSICIAN'S NAME (Type) B. P. Warren				DATE SIGNED 2/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Highland Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham				ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR MAR 2 '59	
24b. REGISTRAR'S SIGNATURE C. P. Kama							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

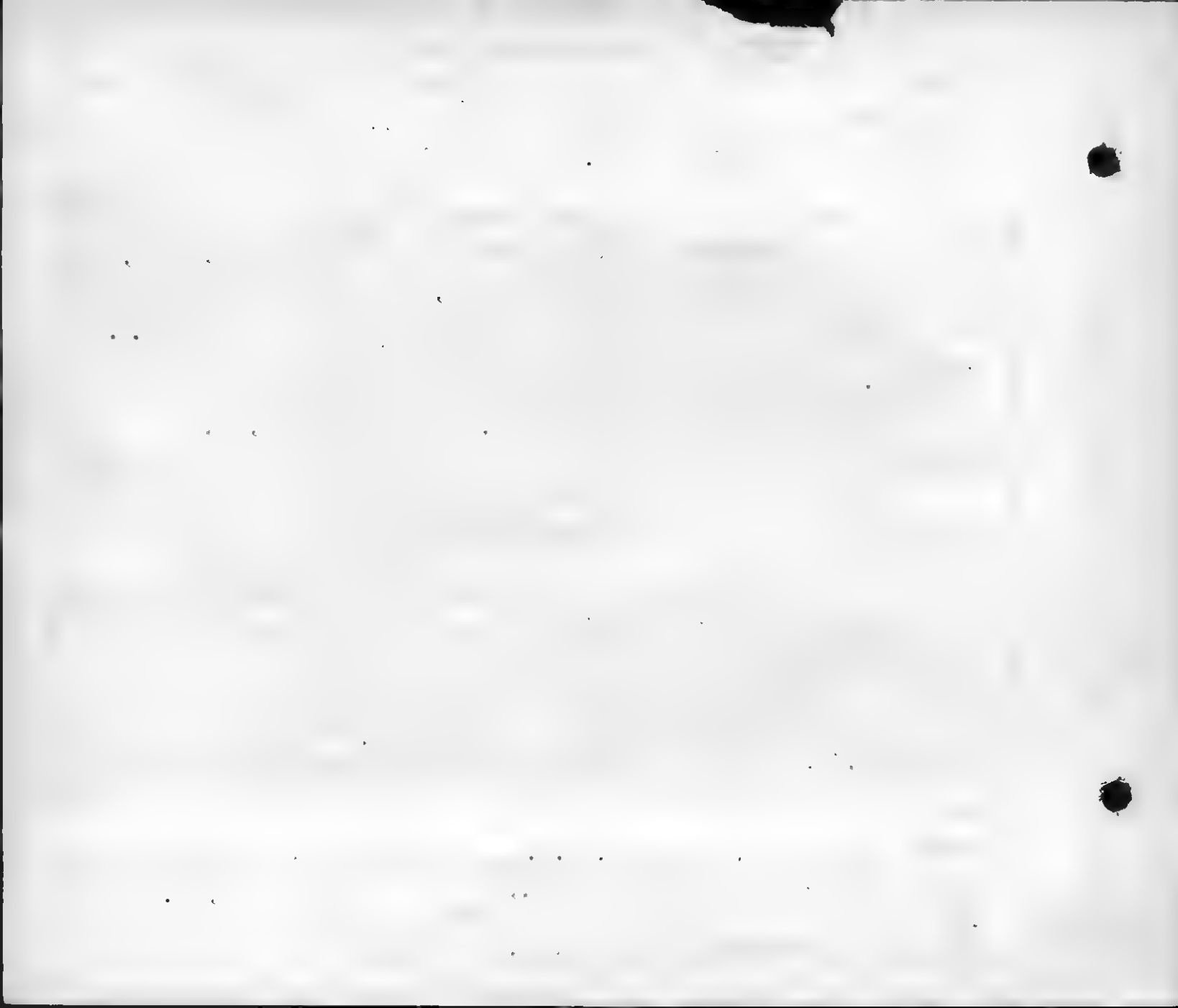
1965

CERTIFICATE OF DEATH

Reg. Dist. No.

01968

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Highland (Rural)		c. LENGTH OF STAY IN 1b 3 Yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland (Rural)		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ISABELLE Middle A. Last SMITH		4. DATE OF DEATH Month Feb. Day 11 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1899
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Allen	
14. MOTHER'S MAIDEN NAME Harriett Dorsey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Mary E. Glover Address Highland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 weeks 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - 8 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 58 to Feb. 11 , 19 59 , that I last saw the deceased alive on Feb. 10 , 19 58 , and that death occurred at 6:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2-11-59			
ACTUAL SIGNATURE Charles S. Whitaker, M.D.		PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D. Clarksville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2/14/59	22c. NAME OF CEMETERY OR CREMATORY Simpsonville..	22d. LOCATION (City, town, or county) (State) Simpsonville, Ma.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sworden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE FEB 17 59 24b. REGISTRAR'S SIGNATURE Arthur L. Kiser	



1966

CERTIFICATE OF DEATH

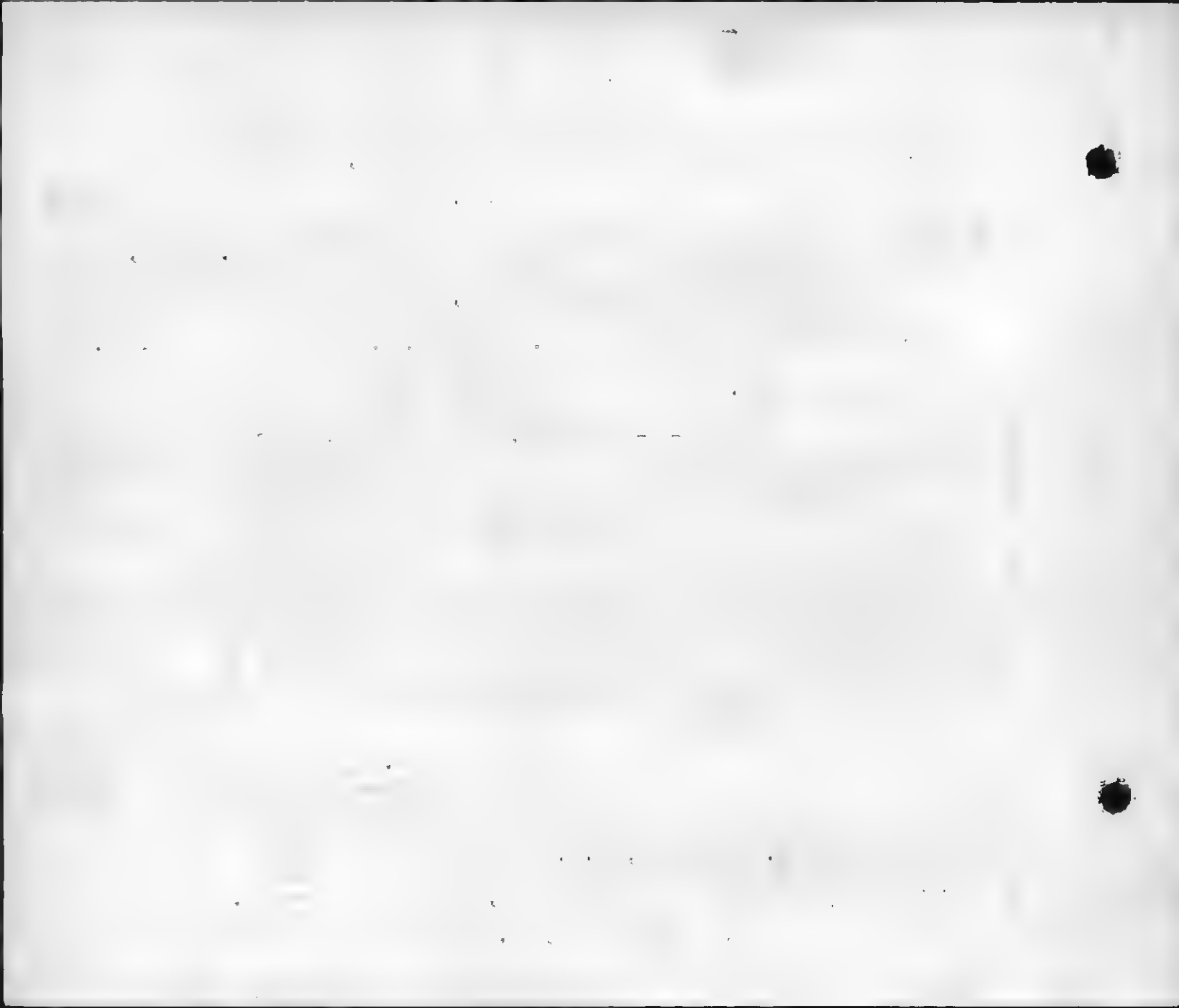
Reg. Dist. No.

01969

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City (Rural)				c. LENGTH OF STAY IN 1b 39 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City, (Rural)			
f. STREET ADDRESS R. F. D # 2				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLIS Middle Last STREET				4. DATE OF DEATH Month Feb. Day 8, Year 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1888	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min		11. IF UNDER 24 HRS: Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY State Road Comm.			
11. BIRTHPLACE (State or foreign country) Bullock, N. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Street.				14. MOTHER'S MAIDEN NAME Mollie Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 214-24-6552		17. INFORMANT Mrs. Maggie Street., Ellicott City, Md. Route 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-21-48 to 2-8-19 59 , that I last saw the deceased alive on 2-6-19 59 , and that death occurred at 1:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles S. Whitaker M.D.				ADDRESS (Street, city or town, state) Clarksville, Maryland			
DATE SIGNED 2-8-59				PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2/11/59		22c. NAME OF CEMETERY OR CREMATORY Browns Chapel.		22d. LOCATION (City, town, or county) (State) Dayton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR FEB 11 1959	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1967

CERTIFICATE OF DEATH

Reg. Dist. No.

01970

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 51 Merryman St				d. STREET ADDRESS 51 Merryman St			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WILLIAMS Last				4. DATE OF DEATH Month Feb. Day 25 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? Maryland			
13. FATHER'S NAME John Williams				14. MOTHER'S MAIDEN NAME Bessie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) WW 1 (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 217-05-2996		17. INFORMANT Daisy Williams, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE HIP DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ACUTE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-23-1956 to 2-5-59 , 19 that I last saw the deceased alive on 2-16-1959 , and that death occurred at 6:11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md DATE SIGNED 2-26-59							
ACTUAL SIGNATURE Donald E. Fisher M.D.				PHYSICIAN'S NAME (Type) Donald E. Fisher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higginbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE Feb 2 59		24b. REGISTRAR'S SIGNATURE W. J. P. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1968

CERTIFICATE OF DEATH

Reg. Dist. No.

01971

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>#Pachawanna</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Massaw</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sumner's Rest Home</u>		d. STREET ADDRESS <u>Main Street</u>	
3. NAME OF DECEASED (Type or print) <u>Maude</u> first <u>Louise</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH <u>February 24</u> 19 <u>59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Saugus, Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Taylor Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Pearson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Philip G. Baker A. Laurel Md</u>	
17. INFORMANT <u>Philip G. Baker A. Laurel Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/27</u> 19 <u>58</u> to <u>2/24</u> 19 <u>59</u> , that I last saw the deceased alive on <u>2/24</u> 19 <u>59</u> , and that death occurred at <u>1:06 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		ADDRESS (Street, city or town, state) <u>CLARKSVILLE, MD</u> DATE SIGNED <u>2/24/59</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>2/25/59</u>	<u>But Lincoln Cem.</u>	<u>Colman Manor Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walt Donaldson</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>FEB 27 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

CERTIFICATE OF DEATH

1908

File No. 10

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1969

CERTIFICATE OF DEATH

Reg. Dist. No.

01972

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 24 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3v01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 3401 Garrison Blvd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last George B. Young				4. DATE OF DEATH February 3 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/16/83	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper (rtd)				10b. KIND OF BUSINESS OR INDUSTRY --			
11. BIRTHPLACE (State or foreign country) Betterton, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Robert C. Young				14. MOTHER'S MAIDEN NAME Annie A. Crew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Fannie B. Young - 3401 Garrison Blvd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. with psychosis due to arteriosclerosis Removal distal third oesophagus (cancer) 1954 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 11 1959, to February 3, 1959, that I last saw the deceased alive on 2/3/59, 1959, and that death occurred at 6:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stephen Lee Magness M.D. Taylor Manor Hospital, Ellicott City 2/3/59 2/3/59 PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D. Taylor Manor Hospital, Ellicott City, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/59		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cem		22d. LOCATION (City, town, or county) (State) Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REG. NO. REGISTRAR		24b. REGISTRAR'S SIGNATURE	
24c. DATE FEB 4 '59				24d. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury	
40. Signature of jury		41. Signature of jury		42. Signature of jury	
43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
100 SOUTH ST. BOSTON, MASS. 02109
TELEPHONE 522-1234
FAX 522-5678
WWW.MASSDEH.HEALTH.GOV